Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN1604	A. BUILDING _____ B. WING _____	04/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANCHESTER HEALTH CARE CENTER	395 INTERSTATE DRIVE MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments During the annual licensure survey and investigation of complaints TN 18262, 19013, 20346, 20718, 22072, 24228, and 25081 conducted at Manchester Health Care Center from April 5, through April 7, 2010, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.	N 000		

Division of Health Care Facilities
Rachel Anderson, Administrator — TITLE — (X6) DATE 4/19/2010
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE